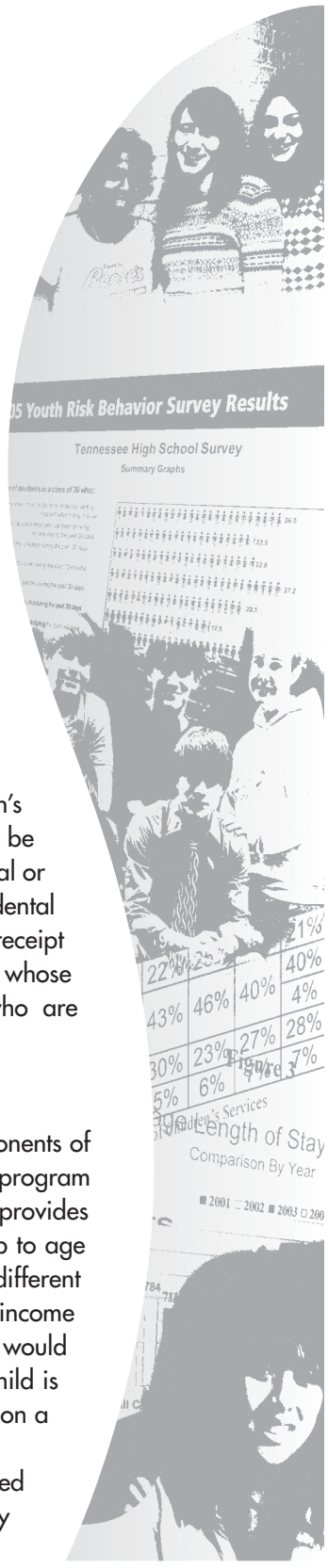
Chapter X

Supporting Vulnerable Youth and Young Adults

Chapter Preview

This chapter includes a description of:

- Children with special health care needs
- Youth in state custody
- Youth receiving special education services
- Runaway and homeless youth
- Youth involved in the juvenile justice system
- State data
- State programs



Vulnerable youth, such as those who are in state custody, homeless, receive special education services, suffer from poverty or lack of health insurance, or have special health care needs tend to be the least healthy members of the adolescent population and therefore need special attention and resources. By improving or impacting the health of vulnerable youth, the health of the overall adolescent population improves. Vulnerable youth and young adults need professionals to assess, assure and advocate for their needs since they often lack the resources to secure their own healthy future.

Children with Special Health Care Needs

Tennessee's Children with Special Health Care Needs program is known as Children's Special Services (CSS). State statue defines special needs children as: "Children shall be deemed "chronically handicapped" by any reason of physical infirmity, whether congenital or acquired, as a result of accident or disease, which requires medical, surgical, or dental treatment and rehabilitation, and is or may be totally or partially incapacitated for the receipt of a normal education or for self-support. This definition does not include those children whose sole diagnosis is blindness or deafness; nor shall this definition include children who are diagnosed as psychotic."

CSS Program Description

Services for children with special health care needs are provided through three components of the CSS program: (1) medical services, (2) care coordination, and (3) a parent support program called Parents Encouraging Parents (PEP). The first component is for medical services and provides reimbursement for medical care, supplies, pharmaceuticals and therapies for children up to age 21 years who meet medical and financial criteria. CSS covers approximately 1500 different diagnoses. To qualify for the medical component, families of the children must have an income level of 200% of poverty or less. If a child has a chronic on-going physical illness that would cause him/her to be delayed as compared to other children of the same age, then the child is usually covered. Many cases due to the varying degrees of severity have to be approved on a case-by-case basis.1

Medical services are provided through a network of CSS and TennCare approved providers. Each child enrolled in TennCare is assigned a primary care provider (PCP) by the TennCare Managed Care Organization (MCO) to serve as the child's medical home.

The CSS program assists families in identifying a medical home for non-TennCare enrolled children. Assessment of medical home and annual well-child screenings are a routine part of the application and recertification process for CSS. Staff coordinate primary and specialty care through the designated PCP and corresponding MCO network.

CSS conducts various multidisciplinary clinics in the regional offices and/or in a university hospital based clinic or other private provider setting. Comprehensive pediatric assessment clinics are only held in 1 of the 12 regions since most CSS enrolled children are also enrolled in TennCare. Better access to primary care providers has reduced the number of comprehensive pediatric assessment clinics needed in the state. In areas of Tennessee where there remains limited access to certain pediatric specialists, CSS continues to provide specialty clinics. Coordination of these clinics occurs between CSS, the PCP and the MCOs. There are six special CSS orthopedic clinics offered; the number has decreased due to more participating TennCare orthopedic providers. Since most children have some form of insurance, including TennCare, every effort is made to obtain reimbursement.

Because there are many categories of eligibility for TennCare, all children applying to CSS must also apply for TennCare. CSS provides for, but limits through program policy, some rehabilitation and medical services, such as transplant surgeries and orthodontic treatment.

All families with children who are newly eligible for Supplemental Security Income (SSI) are contacted by CSS and provided information on CSS, mental health, mental retardation, early intervention (TEIS), genetic services and other health department services that may be available to them. Twenty-six percent, or 1,623 of the 6,244 CSS enrollees have SSI. Staff contact families with newly diagnosed children and provide information on services available.

The second component of the program provides care coordination services by social workers and/or public health nurses in each county. Services promote family-centered, community-based, culturally sensitive, coordinated care. Care coordinators serve as a liaison for the family to medical and other providers and promote advocacy by the family for their special needs child. Care coordinators may attend CSS clinics, private clinics or multidisciplinary meetings with clients and their families. Care coordination may be offered to children not diagnostically or financially eligible for the medical services component. Because the care coordinators have extensive knowledge of community resources, they are often used as contacts within other local health department programs for information and referral. CSS Care Coordination is staffed through a combination of health department staff and contracts with two rural Community Service Agencies and five metropolitan counties.

The third component is the Parents Encouraging Parents (PEP) Program. There are no medical or financial guidelines for PEP. The purpose is to provide parent-to-parent support by matching trained support parents with the parents of children with a disability or chronic illness who are experiencing a time of crisis or transition, or who are seeking information. Parent consultants are themselves the parents of special needs children. The program provides training for parents, community education, outreach, and group support activities. PEP staff work closely with CSS staff and families to strengthen parent-professional collaboration.[2]

CSS Data

As of June 30, 2005, there were 1,397 active clients ages 10 to 21 receiving CSS services. Among this age group, there were 320 different diagnoses. The most frequent diagnoses were: hearing loss (419 clients), cerebral palsy (132 clients), diabetes (64 clients), spina bifida (60 clients), orthopedics (60 clients), cleft/lip and palate (53 clients), asthma (25 clients), and cystic fibrosis (15 clients). The remaining clients represented a wide variety of different diagnoses.

More than twice as many white clients (70%) received services from CSS than African-American clients (27%).[3]

In general, Tennessee served 6,125 children under 18 with special health care needs under Title V (Federal Maternal and Child Health Block grant) during 2004.[4] The majority of these youth served were covered by TennCare (91%) while the remaining services did not have 3rd party reimbursement (3%) or were covered by private insurance (6%). Children with special health care needs comprised 1% of the population served under Title V monies. Thirty percent of the total Federal Title V funds were allocated to services for children with special health care needs.[5]

To create a healthcare system that appropriately meets the needs of this population, often direct medical

services must be provided along with care coordination and services and systems to transition the children into adulthood and adult systems of care.

According to the 2004 Children with Special Health Care Needs Survey results:

- Approximately 59% of children with special health care needs clients served under Title V, were satisfied with services received. This represents an increase of 3% since 2001.
- 60% of all children with special health care needs ages 0-18 indicated that they had received coordinated, ongoing, comprehensive care within a medical home. This represents a 4% increase since 2001.
- 62% of children with special health care needs ages 0-18 indicated they had adequate private and/or public insurance to pay for the services they needed. This represents a 4.4% increase since 2001.
- 80% of families of children with special health care needs ages 0-18 families reported that community-based service systems are organized so they can use them easily. This represents a 4% increase since 2001.
- 25% of youth with special health care needs reported that they received the services necessary to make transition to all aspects of adult life. This represents an increase of 16.8% since 2001.

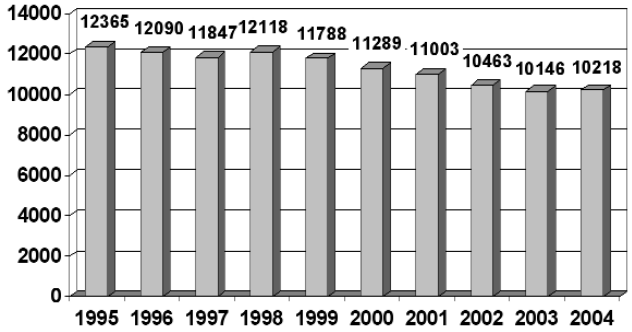
Children in State Custody

Tennessee Commission on Children and Youth staff conduct an annual evaluation of children in state custody.

Figure 1

Population of Children in State Custody

Comparison By Year



Source: Tennessee Department of Children's Services

Evaluation results are reported by the Children's Program Outcome Review Team (CPORT). CPORT reviews are conducted in each of the state's 12 Department of Children's Services (DCS) regions on a random sample of children in state custody sufficient to provide validity at the 95% level statewide and the 80% level regionally. Unless indicated otherwise, all data presented in this section are from the CPORT 2004 Evaluation Report.[6]

Tennessee Data

The number of children and youth in state custody has been steadily declining since 1995. (See Figure 1) As of 2004, there were 10,218 young people in state custody.

Davidson County, East Tennessee, North East Tennessee, and Upper Cumberland regions have seen an increase in the number of children in state custody from

Table 1

Population By Region of Children in State Custody

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Davidson	8.27%	8.74%	8.72%	9.63%	12.45%	11.98%	13.06%	10.40%	10.90%	11.35%
East Tennessee	10.43%	10.17%	9.93%	10.97%	10.30%	11.05%	10.86%	12.31%	12.67%	12.47%
Hamilton County	6.83%	6.89%	7.60%	7.52%	6.25%	6.02%	6.18%	6.31%	6.36%	5.44%
Knox County	6.23%	5.95%	6.04%	6.28%	6.17%	5.99%	5.70%	5.75%	6.53%	6.09%
Mid Cumberland	13.81%	13.52%	11.60%	11.54%	12.22%	12.09%	9.40%	13.41%	12.22%	11.02%
Northeast	7.85%	7.92%	8.72%	7.83%	7.73%	7.73%	8.58%	8.86%	8.78%	9.51%
Northwest	3.14%	3.37%	3.19%	3.14%	3.23%	3.42%	2.87%	3.18%	3.48%	3.56%
Shelby County	16.06%	16.28%	16.85%	16.84%	16.68%	16.14%	16.56%	14.75%	13.59%	13.61%
South Central	6.23%	6.00%	6.85%	6.68%	6.62%	7.23%	6.55%	5.96%	6.59%	6.81%
Southeast	6.89%	6.63%	6.41%	6.09%	6.17%	5.82%	6.32%	5.39%	5.15%	5.78%
Southwest	8.60%	9.15%	8.72%	8.66%	7.77%	7.49%	8.07%	7.96%	7.33%	6.42%
Upper Cumberland	5.66%	5.39%	5.39%	4.82%	4.41%	5.04%	5.85%	5.72%	6.38%	7.93%

Source: Tennessee Department of Children's Services

1995 to 2004. Hamilton County, Mid-Cumberland, Shelby County, Southeast, and Southwest regions have seen a decrease in the number of children entering state custody during this same time period. The remaining counties have not seen significant changes in either direction. (See Table 1)

Adjudications

Most children and youth entering state custody were adjudicated as dependent (73%) followed by delinquent (24%) and unruly (3%). Since 1994 there has been a significant increase in the number of children/youth adjudicated dependent/neglect while the number of children/youth determined unruly decreased substantially. The delinquent category has remained steady. (See Table 2)

Placements

Most children/youth were placed in foster care (48%) followed by group home (18%), family (18%), kinship (12%), and runaway (from placement) (4 %). (See Figure 2)

The number of children and youth placed in foster care has increased from 34% in 1994 to 48% in 2004. At the same time, the number of children and youth placed in group homes has declined from 39% in 1994 to 18% in 2004. Family placements have remained steady during this time period but the number of runaways is at an 11 year low of 4%. (See Table 3)

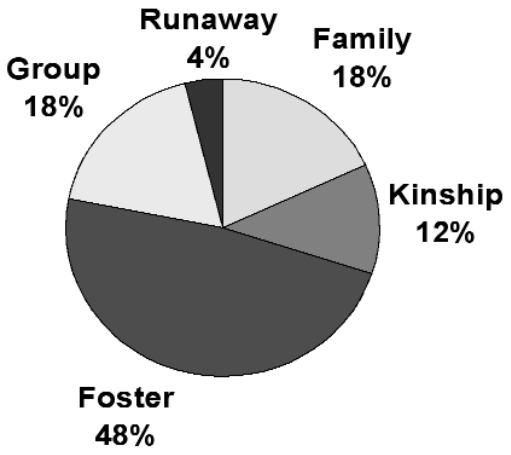
Over half of the children/youth in state custody fall within the 13-17 age group category, followed by ages 6-12 (21%), birth to 5 (20%) and 18 and older (7%).

Average Length of Stay by Age

The average length of stay for all cases reviewed was a little over two years (711 days). The average length of

Figure 2

Placements Tennessee



Source: Tennessee Department of Children's Services

Table 2

Adjudications

Adjudication	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Dependent/Neglect	57%	68%	68%	65%	68%	72%	68%	72%	68%	73%	73%
Unruly	21%	15%	12%	12%	9%	5%	8%	7%	4%	6%	3%
Delinquent	22%	17%	21%	23%	23%	23%	24%	21%	28%	21%	24%

Source: Tennessee Department of Children's Services

Table 3

Placements, 1994-2004

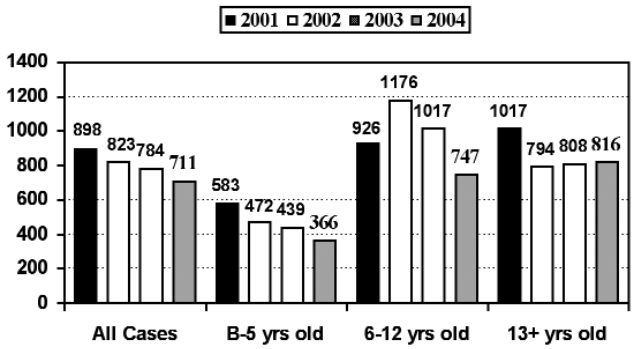
Placements	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Family	20%	19%	26%	22%	22%	25%	26%	21%	20%	18%	18%
Foster*	34%	43%	40%	43%	43%	46%	40%	40%	41%	43%	48%
Kinship*								4%	6%	14%	12%
Group	39%	32%	29%	25%	30%	23%	27%	28%	27%	20%	18%
Runaway	7%	6%	5%	10%	5%	6%	7%	7%	6%	5%	4%

Source: Tennessee Department of Children's Services

Figure 3

Average Length of Stay By Age

Comparison By Year



Source: Tennessee Department of Children's Services

stay in state custody has been declining since 2001 except for the 13 years and older age group which has seen an increase. (See Figure 3)

- 53% of children and youth in state custody were male, and 47% were female.
- There were 58% white children/youth in state custody followed by African Americans (33%) and "other" racial category (9%).

Average Length of Stay by Race

The average length of stay in state custody by race shows that there is a decline for African-Americans and "other" race category and an increase for white children/youth. (See Figure 4)

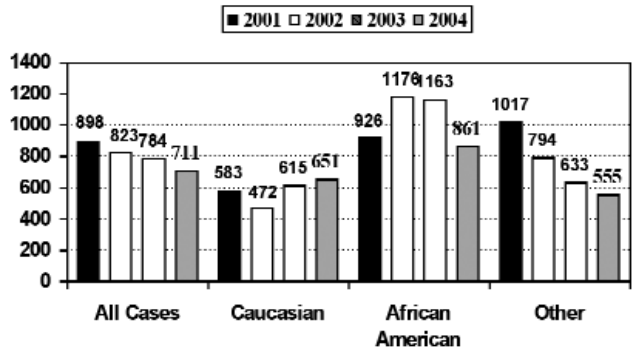
TennCare Services

As children enter the custody of the Tennessee Department of Children's Services (DCS), they immediately receive TennCare eligibility. Only 15% of all cases reviewed by the CPORT evaluation reported any issues with TennCare. The most common areas of concern involved dental services (31%); followed by coverage issues (12%), delay in TennCare eligibility determination (10%), TennCare administration (8%) and access to mental health services (8%). (See Figure 5)

Figure 4

Average Length of Stay By Race

Comparison By Year

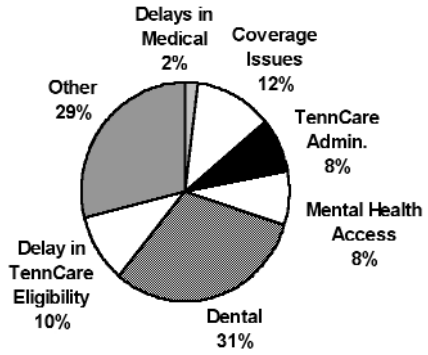


Source: Tennessee Department of Children's Services

Figure 5

TennCare Issues

Issues Reported in 15% of Cases



Source: Tennessee Department of Children's Services

Mental Health Diagnoses for Children/Youth in State Custody

The rate of mental health diagnosis among children/youth in state custody was at a high of 54% in 1994, dropped to a low of 31% in 1998 and has since increased to a rate of 50% in 2004. (See Figure 6)

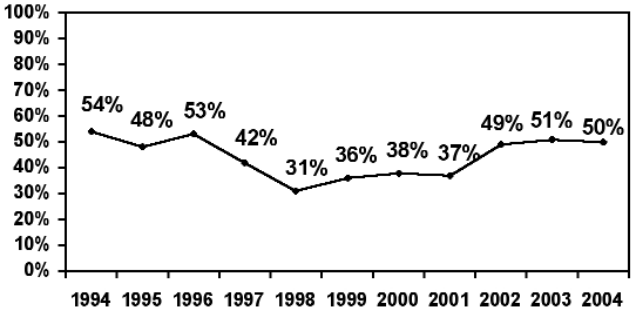
The primary mental health diagnosis for children/youth in state custody was conduct disorder (16%), ADD/ADHD (14%), oppositional/deviant disorder (14%), depression (12%), adjustment disorder (10%), post traumatic stress (4%) and bi-polar disorder (4%).

Sixty-eight percent of those with a diagnosis have multiple diagnoses, 39% have 2 diagnoses, 14% have 3 diagnoses, 9% have 4 diagnoses, and 7% have 5+ diagnoses.

Figure 6

Reported Formal Mental Health Diagnoses

Comparison By Year



Source: Tennessee Department of Children's Services

High Risk Critical Issues

The highest risk for children/youth to be placed in state custody was the child coming from a family with 3 or more siblings (68%), followed by parents who have been or currently are incarcerated (66%), parent has a substance abuse issue (66%), child has little or no relationship with the father (61%), parents never married (52%), or child has a mental health diagnosis (50%). (See Figure 7)

2004 CPORT Findings

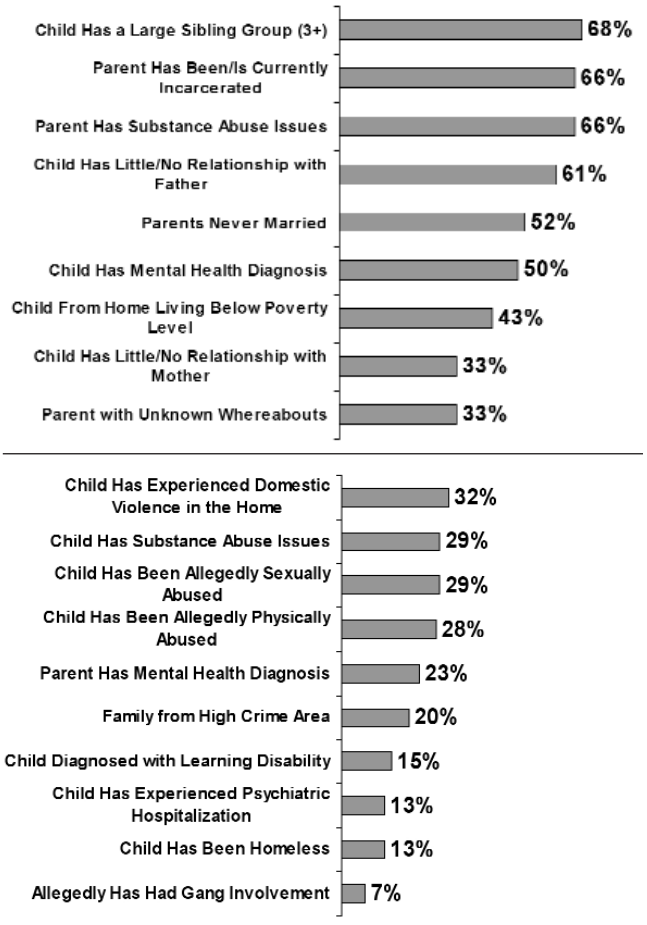
Status of the Child and Family

- Most children in custody were in a positive status (85%).
- Child safety was the highest ever with almost all children safe from harm (96%).
- The emotional well-being of most children in custody was adequately addressed (88%).
- The physical well-being of the great majority of children was adequately addressed at the time of the review (96%).
- Most all children were placed with caregivers who could adequately meet their needs (95%).
- Most children were in stable placements not likely to disrupt (90%).
- In most cases the system had identified an appropriate permanent goal (94%).
- Most children were in the least restrictive, most appropriate placement to meet their needs (93%), and tied with the best year in CPORT reviews.
- Many children were making progress in education or a vocation (84%).
- The lowest indicator was in family satisfaction (65 %).
- Seventy-eight percent of children ages 13 and over were receiving appropriate independent living services, but in many cases services were only minimally adequate.
- In general, the status of a child and family was more likely to be positive overall when the children were ages 12 and under.

Figure 7

High-Risk Critical Issues

All Cases



Source: Tennessee Department of Children's Services

- There were no major differences overall based on race, gender or residence.

Adequacy of Service System Functions

- For the cases reviewed, the service system functioned adequately to meet the needs of the child/family 46% of the time.
- The system intervened at the earliest opportunity with family support services of sufficient scope and intensity 77% of the time.
- In most cases the system adequately identified the long-term view for services (87%).
- The system was engaging most children and their families in the planning and implementation of services, if age appropriate (94% each). This is the best ever for both measures.
- There was an adequate assessment of needs in 68% of cases reviewed.
- Efforts were made to provide home and community based services for most children and families (93%).
- In most cases the system was able to respond to problems of an urgent nature (93%).
- Most children were making progress (89%), especially younger children ages 12 and under, or adjudicated dependent/neglect.
- Advocacy for children was 78% adequate.
- The majority of families were making progress (53%).
- Supportive intervention was provided to achieve the permanent goal in 79% of cases reviewed.
- Areas of deficiency in system performance included Assessment of Needs, Permanency Plan Design, Service Coordination, and Progress Achieved-Family.
- There were no major differences based on gender or adjudication.

Critical Issues

Critical issues are defined as conditions children and families have experienced in their environment that contribute to the risk of children entering or remaining in custody. The top 12 high-risk critical issues are listed below.

- In 93% of all cases the child or a parent had either a mental health diagnosis and/or substance abuse issues.
- 88% of the children adjudicated delinquent have mental health diagnoses/issues.
- 68% of the children were from large sibling groups of three or more.
- 66% of the children reviewed had parents who were or had been incarcerated (87% had been incarcerated and 13% were currently incarcerated).
- 66% of the children had parents with substance abuse issues.
- 61% of the children had little or no relationship with their fathers.
- 52% of the children had parents who had never married.
- 43% of children were from families living below poverty level.
- 42% of the children had been allegedly physically or sexually abused (28% physically abused, 29% sexually abused, 15% both sexually and physically abused).
- 33% of children had little or no relationship with their mothers.
- 33% of children had a parent with whereabouts unknown.
- 32% of the children have experienced domestic violence in the home.

System Observations

Content analysis of strengths and performance issues across 12 Department of Children's Services regions revealed common strengths and weaknesses.

Strengths Identified Statewide

- Most children were appropriate for custody at the time of custody.
- Most children were in the least restrictive, most appropriate placement to meet their needs.
- Most children were with either biological family, kinship (relative/friend), or with a resource family in a foster home.
- Most case managers had an adequate knowledge of the child and family.

- In most cases the TN KIDS (name of data entry system) extract/screens contained accurate information.
- Substantial services had been provided in an effort to prevent custody.
- In almost all cases, when appropriate, siblings were placed together in compliance with Brian A./Best Practices. Brian A is a lawsuit and resulting consent decree that the state of Tennessee is currently working to be in compliance with under the supervision of a Special Master who has been appointed by the court.
- Most children with a goal of reunification were visiting with families in appropriate settings, and most siblings were visiting when appropriate.
- Most children were visited by case managers as required in compliance with Brian A./Best Practices.
- Most children were in placements close to home or in the DCS region.
- Many children were in quality foster homes with foster parents very committed to the children, and many willing to adopt.
- Most all children were receiving Early and Periodic Screening, Diagnosis and Treatment services.
- Four in five children needing special education services were receiving them.
- Most social services caseloads were at the level needed to meet Brian A./Best Practice requirements with an average of 15.7; adoption caseloads averaged 10. Juvenile Justice caseloads averaged 25.7.

Weaknesses Identified Statewide

- The assessment of needs identified for children/families was often inadequate.
- Many Permanency Plans were inadequate, not addressing current issues/service needs of the child and family, and lacking strategies to achieve the permanent goal.
- Service coordination and communication between various system components were often inadequate.
- Many children in the Brian A. class experienced more than two out-of-home placements, ranging from 3 to 28 with an average of five and a median of four for those who had two or more placements. The average total number of placements for all children in custody was four.
- Many children had experienced a change in case managers within the past 12 months because many case managers had been reassigned, and other case managers possessed 12 or fewer months experience.
- Many children stayed in custody too long.
- Truancy or other school problems were major factors contributing to custody for a number of school-age children.
- A number of children did not receive adequate independent living/transition services.
- A number of children experienced lengthy stays (30 days or more) in detention/ emergency shelter/diagnostic shelter awaiting a placement.
- A number of children (19%) experienced multiple custodies: 77%, 4 times; 9%, 3 times; 8%, 6 times; 3%, 5 times; 3%, 2 times.
- A number of children received in-home services/crisis intervention but still entered custody.
- A number of children did not receive timely subsequent dental screenings every six months as required by EPSDT, and hearing and vision screenings were not always adequately documented.
- TennCare sometimes delayed service implementation or provided inadequate services due to insufficient provider network, especially for

mental health services, refusal to pay for specialized services, extended waiting periods at the Health Department, difficulty scheduling appointments, and confusion related to TennCare eligibility.

Coordination and Delivery of EPSDT Services to Children in State Custody

A priority for the Tennessee Department of Children's Services (DCS) is ensuring that children receive health screenings and any identified services resulting from the screen. DCS cares for approximately 10,500 children on any given day, with approximately 600 children entering and exiting custody per month. Consistently, 95% of children in custody are documented as having completed an appointment to receive an Early Periodic Screening Diagnosis and Treatment (EPSDT) screening on an annual basis.

As children enter the custody of DCS, they receive immediate TennCare eligibility, and an appointment is made with the local county health department for a health screening. Since June 2003, all health screenings for TennCare enrolled DCS children are performed at the local health department. The health department provides a health screening appointment within twenty-one (21) days of the request and documents all of the components of the screening provided to the child, and recommends any follow up services. This information is provided to the child's primary care physician (PCP), with a copy sent to DCS within two (2) working days from the screening. DCS tracks appointments kept for health screenings, as well as documents the components provided, in the TN KIDS information system.[7]

Juvenile Justice

Incarcerated Youth

As of June 30, 2004, there were 4,827 inmates ages 24 and younger within the custody of Tennessee's Department of Correction. This represents 18% of the total Department of Correction (DOC) population.[8]

- 30 juveniles (ages 16–17) were within the custody of DOC.
- As age increases the number of inmates increase. The vast majority ((92%) of youth/young adults incarcerated are 20-24 years of age.
- Most juveniles in DOC custody are male (93%) and African-American (78%).
- The majority of juvenile felons are from Davidson County (24%) and Shelby County (28%).
- Robbery (56%) is the most common offense, followed by assault (15%), burglary (7%), homicide (7%) and theft (4%).[9]

Tennessee Department of Children's Services

The Tennessee Department of Children's Services (DCS) oversees treatment services for youth in state custody due to delinquency determinations. DCS operates 4 youth development centers and 8 community residential programs designed to support the needs of this population group. In 2004, there were 2,452 young people in state custody due to delinquency determinations.[10]

Students Receiving Special Education Services

Tennessee Data

110,930 children and youth ages 6-21 received special education services in Tennessee as counted on December 1, 2004. Of these children and youth, 44% were diagnosed with specific learning disabilities followed by speech or language impairment (22%), mental retardation (12%), other health impairments (10%), emotional disturbance (3%), developmental delay (3%), autism (2%), multiple disabilities (2%) and hearing impairments (1%).

- The majority of students receiving special education are white (70%), followed by African-American (28%), Hispanic (2%), Asian or Pacific Islander (0.4%), and American Indian (0.1%).**11**
- There were 104 children/youth through age 21 who received special education services in correctional facilities as counted on December 1, 2004.[12]
- 540 children/youth in special education were suspended or expelled from school during the 2003-2004 school year.[13]

Runaways and Homeless Youth

National Data

Currently, there is an estimated 1.5 million runaway and homeless youth in the United States.[14] According to the National Runaway Switchboard, one in 7 young

people between the ages of 10 and 18 will run away.[15]

Tennessee Data

No state agency collects general data on runaways and homeless youth in Tennessee. However, the Department of Children's Services (DCS) measures runaway status on children in state custody. The DCS active custody population as of July 31, 2005, was 9,804 children. Of those, 349 or 3.6% were on runaway status as of July 31, 2005.[16]

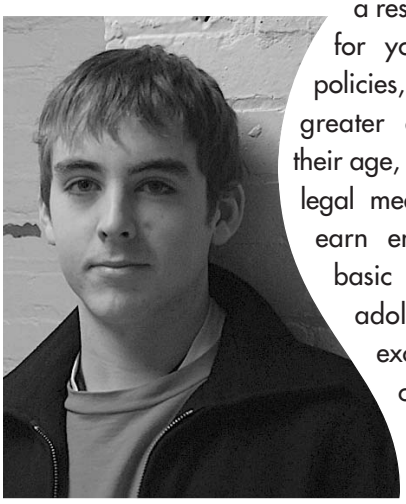
Nashville Data

In 2003, the Youth Services Division of the Nashville Metropolitan Police Department received reports of 2,089 runaway youth, a slight decrease from the previous year (2,201), but in keeping with the Department's three year average of 2,130.[17]

Conditions of Youth/Families

In 2003, the National Alliance to End Homelessness summarized the primary reasons that youth experience homelessness:

- family conflict,
- physical abuse (40-60%),
- sexual abuse (17-53%), or emotional abuse by others in the home,
- parental disapproval of pregnancy, sexual orientation, school problems, drug/alcohol use, or "other circumstances of their children".[18]



Homeless youth face many challenges on the streets. Few homeless youth are housed in emergency shelters as a result of lack of shelter beds for youth, shelter admission policies, and a preference for greater autonomy. Because of their age, homeless youth have few legal means by which they can earn enough money to meet basic needs. Many homeless adolescents find that exchanging sex for food, clothing, and shelter is their only chance of survival on the streets. In turn, homeless youth are at a greater risk of contracting AIDS or HIV-related illnesses. HIV prevalence studies anonymously performed in four cities found a median HIV-positive rate of 2.3% for homeless persons under age 25. Other studies have found rates ranging from 5.3% in New York to 12.9% in Houston. It has been suggested that the rate of HIV prevalence for homeless youth may be as much as 2 to 10 times higher than the rates reported for other samples of adolescents in the United States.[19]

Homeless adolescents often suffer from severe anxiety and depression, poor health and nutrition, and low self-esteem. In one study, the rates of major depression, conduct disorder, and post-traumatic stress syndrome were found to be 3 times as high among runaway youth as among youth who have not run away.

Furthermore, homeless youth face difficulties attending school because of legal guardianship requirements, residency requirements, proper records, and lack of transportation. As a result, homeless youth face severe challenges in obtaining an education and supporting themselves emotionally and financially.[20]

Tennessee Vulnerable Population Programs

Tennessee Department of Health

Children's Special Services

Children's Special Services (CSS) provides services to eligible children with special health care needs. CSS has three components: medical services, care coordination, and the *Parents Encouraging Parents* program.

The first component provides medical services and reimbursement for medical care (surgery, physicians/clinic visits), medical supplies, pharmaceuticals and therapies for children to age 21 years who meet medical and financial criteria.

The second component is *care coordination*. CSS coordinates primary and specialty care through the

designated primary care physician and corresponding managed care organization network. Care coordinators assist the family in accessing many services (educational, medical, social, transportation, support, and advocacy).

The third component, *Parents Encouraging Parents*, links parents/families of children with special health care needs with other parents/families whose child may have the same or similar disorder. CSS employs a team of a parent of special needs child and a nurse or social worker to provide the support, linking and training for parents to assist them in the role of a support parent for other families.

For more information about Children's Special Services, visit their website at http://www2.state.tn.us/health/MCH/css.htm.

Tennessee Department of Children's Services

Foster Care Services

Foster homes provide a stable caring environment to children. Foster children come in all shapes, sizes, ages and have individual needs and preferences. The department provides a variety of environments which address these individual needs.

Grandparents, aunts, uncles, cousins, and siblings are excellent resources to care for their minor relatives who enter the foster care system. Relative caregivers are provided with the same support as non-relative caregivers and must meet the same criteria to become an approved foster home.

In Tennessee, there are also private agencies which train and support families to care for children in foster care. These agencies must meet guidelines and criteria outlined by the Department of Children's Services. With the approval of the local Children's Services Office, Shared Homes are foster homes shared with private agencies.

Foster Homes for the Medically Fragile serve children who have extraordinary medical needs which require special attention. Emergency Foster Homes are only for children who are without a placement prospect for the approaching night and for whom no placement is expected to be available.

Youth Development Centers

The Department's four youth development centers are state-operated, hardware-secure, residential facilities that provide treatment programs for delinquent youth ages twelve to nineteen. All students participate in a classification and orientation program. Based on the results of this evaluation, an individualized program plan (IPP) is developed for each child. Objectives are developed to assist in the development of skills which allow the student to move to a less restrictive setting as soon as possible.

A full program of education, vocational skills, medical services, recreational programs, self help and independent living skills is provided. Specialty services include therapy for a broad range of needs, alcohol and drug programs, speech therapy, dental care and behavior management. Students are prepared for release through planning with staff.

The four youth development centers (Mountain View Development Center, Taft Youth Development Center, Wilder Youth Development Center and Woodland Hills Youth Development Center) house a total of 588 young people and provide a number of services from counseling to sex offender treatment. The typical student of a Youth Development Center is likely to have committed a violent offense toward another person, and may have mental-health problems or other specialized needs.

Community Residential Programs

The Department of Children's Services operates nine community residential program homes throughout the state. These minimum-security homes have residential programs in place that are designed for youth who, through evaluation, have been determined to be appropriate for community placement. The primary focus is to provide a structured program, which includes academics, community involvement and an individual program plan. All youth are afforded the opportunity to reintegrate into their home community through the provisions of counseling services, education and, in some cases, community service or actual work experience.

The homes provide a wide range of treatment services, including individual and group counseling, medical/dental treatment, recreation, academic and vocational training, transportation, substance abuse rehabilitation and more.

Five of the homes have in-house schools designed for students who have experienced problems with adjustment in public schools. Several of the programs have strong work components and offer independent living skills, as well as money management training for older students.

To access more information about Tennessee Department of Children's Services programs, visit their website at http://www.state.tn.us/youth/index.htm.

End Notes

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